Permission Form for Give Kids a Smile Dental Program

Please PRINT in ink within the boxes

		___/___/___	M F
Child's first name	**Child's last name**	**Child's birth date**	**Child's gender**

Parent/guardian's first name(s)	**Parent/guardian last name(s)**

Address	**City**	**State**	**Zip**

First Phone#:	**What race do you consider your child?**
Second Phone #:	Black ☐ White ☐ Multiracial ☐ Asian ☐ Hawaiian Native ☐
Email Address:	American Indian/Native Alaskan ☐ Other Pacific Islander ☐
Emergency Contact: _____ Contact's Phone #: _____	Other ☐ _____

	Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐
Child's ID Number (Medicaid or Hawk-i)	

Child's school	**Teacher**	**Grade**

Is your child eligible?

What type of dental insurance does your child have? Please circle the number that applies.

1. Private **dental** insurance: ☐ United Concordia ☐ Delta Dental ☐ Metlife ☐ Aetna ☐ Other_____
2. ☐ Medicaid (Medical Card, Title 19), ☐ Meridian, or ☐ Hawk-i
3. No dental insurance

Where does your child go for dental care? Please circle the number that applies.

1. Family Dentist Name of dentist: _____

Last dental visit? Less than six months More than six months/less than a year Over a year Don't know

2. CHC (Community Health Care)

Last dental visit? Less than six months More than six months/less than a year Over a year Don't know

3. School/dental bus

Last dental visit? Less than six months More than six months/less than a year Over a year Don't know

4. No dental home

For office use only:

PLEASE SEE OTHER SIDE

Important Health History:

Your child's Medical History

Anemia	Yes ☐ No ☐	Heart Ailment or Angina	Yes ☐ No ☐
Blood Disorder	Yes ☐ No ☐	Heart Murmur, Heart Defect	Yes ☐ No ☐
Bleeding Disorder	Yes ☐ No ☐	Artificial Heart Valve	Yes ☐ No ☐
High Cholesterol	Yes ☐ No ☐	Heart Attack	Yes ☐ No ☐
Thyroid Problems	Yes ☐ No ☐	High/Low blood Pressure	Yes ☐ No ☐
Leukemia	Yes ☐ No ☐	Pace Maker	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Artificial Joints	Yes ☐ No ☐
Radiation Treatment	Yes ☐ No ☐	Rheumatoid Arthritis	Yes ☐ No ☐
Osteoporosis	Yes ☐ No ☐	Chronic Pain	Yes ☐ No ☐
Hepatitis and/or Liver Problems	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐
Kidney Disease	Yes ☐ No ☐	Stomach Disorder	Yes ☐ No ☐
Tuberculosis	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐
HIV/AIDS	Yes ☐ No ☐	Seizure Disorder	Yes ☐ No ☐
Downs Syndrome	Yes ☐ No ☐	Brain Injury	Yes ☐ No ☐
Autism	Yes ☐ No ☐	Cerebral Palsy	Yes ☐ No ☐
Fainting/Dizziness	Yes ☐ No ☐	Pregnancy	Yes ☐ No ☐
Hearing Difficulties	Yes ☐ No ☐	Fever Blisters and/or Cold Sores	Yes ☐ No ☐
Chronic Earaches	Yes ☐ No ☐	Headaches	Yes ☐ No ☐
ADHD/ADD	Yes ☐ No ☐	Mental/Physical Disabilities	Yes ☐ No ☐
Asthma Yes ☐ No ☐ Carries Inhaler?	Yes ☐ No ☐	Triggers for Asthma:	
Any Surgeries?	Yes ☐ No ☐	List Surgeries/Dates:	
Caffeine Use?	Yes ☐ No ☐	If so, how much/how often?	

Allergies:

Latex	Yes ☐ No ☐	**Does your child require an antibiotic before a dental procedure?** Yes ☐ No ☐	
Nut	Yes ☐ No ☐		
Food	Yes ☐ No ☐		
Anesthetics	Yes ☐ No ☐		
Metal	Yes ☐ No ☐		
Others	Yes ☐ No ☐		

Please List:

List Medications Taken:

Medication	Dose	How often?

Your Child's Dental History

Gum Disease	Yes ☐ No ☐	TMJ	Yes ☐ No ☐

Bleeding Gums	Yes ☐ No ☐	Teeth Grinding	Yes ☐ No ☐
Easily Gags	Yes ☐ No ☐	Difficulties Chewing Food	Yes ☐ No ☐
Sensitive and/or Painful Teeth	Yes ☐ No ☐	Lip Sucking	Yes ☐ No ☐
Nail Biting	Yes ☐ No ☐	Thumb Sucking/Pacifier Use	Yes ☐ No ☐
Mouth Breather	Yes ☐ No ☐	Speech Impairments	Yes ☐ No ☐
Brushing two times per day	Yes ☐ No ☐	Flossing Daily	Yes ☐ No ☐
Tobacco Use	Yes ☐ No ☐	Sticky Food Consumption How often:	Yes ☐ No ☐
		Sweet Consumption How often:	Yes ☐ No ☐
		Soda/Pop Consumption How often:	Yes ☐ No ☐

Type Used	How Often?

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Sealants Placed: 2 ☐ 3 ☐ 14 ☐ 15 ☐ 18 ☐ 19 ☐ 30 ☐ 31☐

Health History reviewed by: _____ Dentist's Initials _____ Date: _____

WAIVER

Please read the waiver below and initial after each permission if agreed to.

I give permission for my child to be treated on the dental bus provided by Bethany for Children & Families' Give Kids a Smile Dental Program. **_____ Initial**

I give permission for Bethany for Children & Families to transport my child from their school to the dental bus if it needs to be parked off-site. **_____ Initial**

I give permission for my child to be treated in a dental office/clinic if follow up work is needed. **_____ Initial**

I give permission for Bethany for Children & Families to transport my child to a follow up dental appointment, if I am not able to take or do not have transportation. Transportation will be arranged on a case by case basis. **_____ Initial**

If my child needs a specialist: Pedodontist (child dentist), endodontist (root canal), Oral Surgeon (tooth extractions), Periodontist (Gum Disease), or Orthodontist (braces), I agree to go with my child to this appointment. **_____ Initial**

I give permission for audits to be performed and professional providers to return to my child's school to recheck his/her sealants and reseal if needed. **_____ Initial**

X Signature _____ Date _____

Parent/Guardian/Legal Custodian Signature

Acknowledgement of receipt of Give Kids a Smile Notice of Privacy Practices

I, as the parent or guardian, have received a copy of the Give Kids a Smile® Notice of Privacy Practices.

X Signature _____ Date _____

Parent/Guardian/Legal Custodian Signature

Permission and acknowledgement valid for one year from the date of signature

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For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)